Credit Card Authorization Form

PLEASE PRINT, COMPLETE, AND RETURN THIS AUTHORIZATION.
All information will remain confidential.

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

Amount to Charge: $ _____ (USD)

I authorize Spafford Ackerly of Medical and Scientific Editing to charge the agreed amount listed above to my credit card. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Signed: _____

Dated: _____

Name: _____

Once signed return the completed form to:

SciTechPro
PO Box 341
Rollinsville, CO 80474
USA

Via FAX: 001-267-645-6036 (USA)